DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		155711	B. WING				C 1 16/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2926 N CAPITOL AVE INDIANAPOLIS, IN 46208			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)			(X5) COMPLETION DATE
F 000	00 INITIAL COMMENTS		F	000			
	This visit was for the IN00128113 and Com	Investigation of Complaint nplaint IN00128557.					
	Complaint IN0012811 lack of evidence.	3 unsubstantiated due to					
	Complaint IN0012855 lack of evidence.	7 unsubstantiated due to					
	Survey dates: May 1	5, 16, 2013					
	Provider number: 1	00567 155711 00289560					
	Survey team: Connie Landman RN	тс					
	Census bed type: SNF: 2 NF: 12 SNF/NF: 24 Total: 38						
	Census payor type: Medicare: 2 Medicaid: 35 Other: 1 Total: 38						
	Sample: 3						
	compliance with 42 C 410 IAC 16.2 in regar	thcare was found to be in FR Part 483, Subpart B and d to the Investigation of					
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000	Continued From page Complaint IN0012811 IN00128557. Quality Review 05/17	3 and Complaint	FOO				